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A Study of Percieved Benefit and Barriers towards the Uptake of State Health Insurance Scheme in Lokoja, Kogi State, Nigeria

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Abstract:*The main objective of this study was to determine the level of percieved benefit andbarriertowards the uptake of and willingness to enrol into the health insurance scheme in Lokoja, Kogi State, Nigeria.*
A cross sectional survey design was employed in this study, a total number of 335 respondents participated in this study. A structured and validated questionnaire with reliability 0.746 was used for data collection and thereafter administered to the participants through direct approach. Multi stage sampling technique method was adopted in administering 195 questionnaires on civil servants while purposive sampling was used to administer 140 questionnaires on artisans. The questionnaire was divided into seven (7) sections in order to get data on respondent's demographic characteristics, awareness, attitude, perception, perceived susceptibility, perceived benefits and perceived barriers to health insurance.
Hypotheses were formulated and tested. Data analysis was done using descriptive statistics and correlation which were statistically tested at 0.05 level of significant using Pearson product moment analytical procedure.
. The results revealed that the level of perceived benefits and barrier of the respondents.
The study concluded that there is a low level of awareness regarding health insurance schemes among the civil servants and artisans in Kogi State. Therefore, regular seminars and trainings should be regularly conducted to disseminate information to civil servants, artisans and the general public on the benefits of health insurance scheme and also, eradicate misconceptions due to lack of adequate information.

Keywords*: Percieved benefit, Barrier, Health insurance, National health insurance scheme*

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I. Introduction

Health Insurance is not a modern idea. It has a long history. Although Awosika, (2005), stated that the history of health insurance (HI) is as ancient as the history of mankind, nevertheless, Germany can be mentioned as one of the earliest countries which commenced HI nationally. In 1883, Emperor Otto Von Bismarck enacted a mandatory regulation on the "sickness funds.'' after which different models of health insurance plan have continued to evolve around the world, directed at achieving the same objectives. Indeed, health insurance has become a global phenomenon. Countries around the globe now adopt different health financing mechanisms in the form health insurance to ensure universal access to primary and quality healthcare for the populace. (Alhassan & Nketiah-Amponsah 2016).

According to the World Bank, the system is practised in more than 60 countries of the world (World Bank, 2006). Many European countries like Finland, Iceland, and Belgium have since embarked on healthcare reforms by introducing Social Health Insurance (SHI) for accelerated effectiveness and consumer satisfaction in the provision of health care services (Stefan, 2004). Awosika (2005) defines Insurance in its easiest form, as a risk-transfer mechanism in which the insured agrees to make small repayments called premium to another party (the insurer), in return for the fee of a giant sum(benefit) on the prevalence of a specified event. Health insurance is, therefore, a social security system for pooling health-risks and costs of an exposure unit with

a view in the direction of predictability. (Awosika, 2005)

According to Conn and Walford (1998), health insurance as a package deal that protects insured persons from paying outrageous treatment charges during the incidence of sickness. The fundamental health insurance technique is that a customer makes a regular fee to a managing institution. This organization is responsible for holding the repayments in a fund and paying a healthcare issuer for the value of the consumer's care.

It took many years for many developed countries to have SHI schemes (WHO, 1999). Some of the high-income countries which are successful in SHI can be found in developed countries. They include, amongst

others;Germany, France, Belgium, Japan, Korea and Switzerland (World Health Organization, 1999). Countries such as Australia and Canada have been successful in accurately financing the health needs of their populace via a combination of public and personal health insurance plan structures (Dalinjong & Laar 2013). A replica of NHIS in South Africa is called the National Health Information System of South Africa (NHIS/SA). Its predominant purpose is to provide affordable healthcare for the people of South Africa at the local level. It is also extended to the district, provincial and national levels, including the non-public and public sectors. The health need of an ordinarySouth African is reportedly nicely taken care of by way of this scheme (Kujenya, 2009)

Unfortunately, health care access through health insurance plan in some developing countries remains confined due to socio-economic challenges (Amu & Dickson 2016). These challenges are mainly experienced in Africa, a continent recognized to have a strong tendency for threat distribution throughout populations and time (Wagstaff, 2010). Thus, various African countries, including Ghana, Kenya, Nigeria, and Tanzania, presently have health insurance options at the general population level, most of which are public schemes. (Aryeetey 2016, Unumeri, 2009; Mulupi, Kirigia & Chuma 2013; Kenya national health accounts 2009-2010; Lekashingo, 2012)

In order to provide equitable access to healthcare delivery in Nigeria, the Federal Government introduced the National Health Insurance Scheme (NHIS) through the promulgation the National Insurance Scheme Act, 1999 (Act 35). Through the instrumentality of the Act, a number of programmes that covered different sectors of the country were introduced. (Arin & Hongoro 2013). The scheme itself has a chequered history. It should be mentioned here that the thought of the scheme was conceived as far back as 1962. It, however, took almost three decades to manifest. Lack of political will through successive governments, both civilian and military was a major impediment to its implementation. It is also significant to mention here that, although NHIS has been in existence for some years now, the scheme has been bedevilled by a lot of challenges and constraints such that its effectiveness is in doubt. One of such doubts is the uncertainty as to whether there are enough understanding and capacity to operate an insurance-based health system in an environment where corruption, lack of transparency and accountability pervade (Health Insurance Report 2005). For instance, it is on record that since its inauguration, social health insurance in Nigeria currently covers less than 5% of the country's working population. (Uzochukwu, Ughasoro Etiaba, Okwuosa, Envuladu & Onwujekwe 2015)

Ghana's National Health Insurance Scheme came into operation in 2003 with the enactment of the National Health Insurance Act, 2003. The scheme seeks to enhance access to health care for all residents of Ghana through public financing. The scheme is financed with deductions from the pension contributions of workers in the formal sector (2.5% of Social Security and National Insurance Trust contributions), a 2.5% insurance plan levy as Valued Added Tax (VAT) on goods and services, and annual premiums paid via subscribers who are 18 years and above (National Health Insurance Authority NHIA 2012). The scheme is also financed with voluntary contributions, donations, gifts, grants, investments, and economic allocations made to the Health Insurance Fund (HIF) by using Ghana's legislature (parliament) (Boakye-Frimpong, 2013). It is, however, significant to state here that, in Ghana, children below 18 years of age, pensioners with Social Security and National Insurance Trust contributions, the elderly (70 years and above), pregnant women, the indigent, and Livelihood Empowerment Against Poverty (LEAP) beneficiaries, constitute exemptions from payment of the annual premiums. (Duku, Asenso-Boadi, Nketiah-Amponsah & Arhinful, 2016) From an initial insurance of 6.3% in 2005, when true enrolment into the scheme started, the whole insurance in Ghana presently stands at approximately 38% (Kumi-Kyereme, Amu & Darteh 2017)

Kenya has two important health insurance schemes – the National Health Insurance Fund (NHIF), set up in 1966, and the National Social Security Fund (NSSF), established in 1965. (Kiplagat, Muriithi & Kioko 2013). Membership in the NHIF is obligatory for all workers in the formal sector but voluntary for informal sector workers. Even though the NHIF Act mandates it to cover both out and inpatient care, insurance is currently restrained to only inpatient care (Muiya & Kamau 2013) Aside from the provision of monetary security, the NSSF provides contributors with basic protection in opposition to widespread sickness and/or disability, employment injury, and the charges of maternity leave (Kiplagat, Muriithi & Kioko, 2013). Under this scheme, subscribers pay premiums related to the anticipated price of providing services, and it additionally has a community-based health insurance plan (CBHI), which is organized at the community level. Despite the existence of exclusive financing schemes, health insurance plan presently covers 10% of Kenya's populace (Abuya, Maina & Chuma 2015)

The National Health Insurance Scheme (NHIS) is a social health insurance programme established to aid healthcare financing in Nigeria. Figure 2.1 shows the various groups in the scheme. The formal or organized sector covers the public sector, organized private sector, the armed forces and students of tertiary institutions. The informal sector includes the rural community and urban self-employed while the vulnerable group includes the permanently disabled, children under five years of age and prison inmates. Others would include international travellers, pregnant women and orphans as well as retirees and the unemployed. The scheme took

off in the formal sector in 2005. Until its commencement, the cash-and-carry system was the only available option.

The scheme has the following specific objectives, (NHIS Decree 35, part 11 s.5):

(a) Ensure that every Nigerian has access to good healthcare services;
(b) Protect families from the financial hardship of huge medical bills;
(c) Limit the rise in the cost of healthcare services;
(d) Ensure equitable distribution of health care cost among different income groups;
(e) Maintain high standard of healthcare delivery services within the scheme;
(f) Ensure efficiency in healthcare services;
(g) Improve and harness private sector participation in the provision of healthcare services;
(h) Ensure adequate distribution of health facilities within the Federation;
(i) Ensure equitable patronage of all levels of health care;
(j) Ensure the availability of funds to the health sector for improved services. (Decree 35 1995).

II. Methodology

Research Design

This studyadopted a descriptive cross-sectional design amongst civil servants and artisans in Kogi State. The study wascarried out with the use of semi-structured, interviewer-administered questionnaire. All ethical considerations were strictly observed in the series of data.

Population

The population of the study comprises of artisans and civil servants in Lokoja local government. The research population consisted of businesses that include (mechanics, vulcanizers, panel beaters, barbers, tailors, and hairdressers) artisans while for civil servants; itcut across civil servants in chosen ministries within Kogi State government barring those above the cadre of grade level 14.

Sample size and sampling Technique

The sample-size for this study wasdetermined by means of making use of Leslie Fischer's formulation as is the popular technique of randomization and identify the restrict of mistakes considered as the most indispensable items in the survey. These assisted the researcher gain sample and use the result to make sampling selections based on data in order to determine the level of awareness, attitudes, and perception of enrolees in the direction of the uptake of the Kogi State Health Insurance Scheme in Lokoja. Therefore, the minimum pattern measurement (N) required for the study was

$$N = \frac{Z\alpha^2 \times P(1-P)}{D^2}$$

Where $Z\alpha$ = standard normal deviant using 95% confidence limit = $(1.96)^2$

D = margin of error tolerated = 0.05

P = prevalence of perception (attitude) of 250 Nigerian dentists to the NHIS in Lagos State as a good idea = 70.4% = 0.704. (Adeniyiand Onajole 2010)

$$N = \frac{1.96^2 \times 0.704\ (1-0.7042))}{0.05^2} = 320$$

Therefore, the minimum total population to be studied is 320

In order to accommodate an expected non-response of about 10% of respondents, the total number of questionnaires that were distributed was three hundred and fifty-two (352) questionnaires.

Sampling Techniques

All workers in the employment of Kogi State government constituted the reference population; those in Lokoja within the secretariat complex formed the target population while sampled workers constitute the study population. The choice of administering the questionnaire was informed by the fact that an enormous population of Kogi State residents are mostly civil servants. While 150 registered artisans in Lokoja were sampled using purposive sampling technique

For civil servants:

In stage one, seven out of fourteen ministries that exist within the state were chosen at random using simple balloting. In stage two, nine out of eighteen blocks in a ministry was chosen using systematic sampling. In stage three, workers below grade level 14 on duty that consented to partake in the study were conveniently administered the research questionnaires.

For the artisans:
Major groups of artisans with associations (mechanics, vulcanizers, panel beaters, barbers, tailors, and hairdressers) were identified with at least 25 members. Hence, the instrument was administered using purposive sampling to all members of these groups attending the association meeting in order to meet up with the sampling frame.

Research Instruments
A semi-structured instrument was designed and used to elicit information from the respondents on the topic of study. The instrument was designed in a simple and understandable way to allow respondent to fill out the information required in few minutes. The questionnaire with the measurement scale of responses is divided into seven (7) sections thus
Section A: Demographic data of respondents. It sought to elicit information that consists of the gender of respondents, the ethnicity they belong, their educational attainment, their marital status, their ages as well as occupation.
Section B: The level of awareness of civil servants and artisans towards health insurance which consists of 5-item with 5-option Likert-type response format: (Strongly Agree, Agree, Undecided, Disagree and Strongly Disagree). The variable was measured on a 20-point rating scale.
Section C: The attitude of civil servants and artisans towards health insurance which consist of 5-item with 5-option Likert-type response format of (Strongly Agree, Agree, Undecided, Disagree and Strongly Disagree). The variable was measured on 20-point rating scale.
Section D: Perception of civil servants and artisans toward health insurance which consist of 7-item with 5-option Likert-type response format: (Strongly Agree, Agree, Undecided, Disagree and Strongly Disagree). The variable was measured on a 28-point rating scale
Section E: Perceived Susceptibility/Severity due to Non-usage of Health Insurance Scheme insurance which consists of 5-items with 5 option Likert-type response format (Strongly Agree, Agree, Undecided, Disagree and Strongly Disagree). The variable was measured on 20-point rating scale
Section F: Perceived benefits of health Insurance Scheme which consists of 5-Items with 5 Option Likert-Type Response Format (Strongly Agree, Agree, Undecided, Disagree and Strongly Disagree). The variable wasmeasured on 20-Point Rating Scale
Section G: Perceived barriers to health Insurance Scheme which consists of 5-Items with 5 Option Likert-Type Response Format (Strongly Agree, Agree, Undecided, Disagree and Strongly Disagree). The variable was measured on 20-Point Rating Scale

Validity of Research Instrument:
The instrument was therefore, given to the researcher's supervisor and her observation was used to correct the items in the research instrument

Reliability of Research Instrument
To ascertain the reliability of the instrument, a pilot-test was conducted for internal consistency of the instrument using 10% of the projected sample size (35 civil servants and artisans) from Kogi State Ministry of Local Government and Chieftaincy Matters and some selected artisans in Ibadan. The data from the pilot study was statistically analysed using Cronbach alpha standard score to test its reliability. Hence, a Cronbach alpha score of 0.746 was obtained which ensured the reliability of the instrument.

Method of Data Collection
The data collection instrument for this study was a structured, close-ended questionnaire. The copies of questionnaire were administered to the respondents with the help of four research assistants. This method adopted enabled absolute and accurate capture of data from respondents.

Method of Data Analysis
In this study, the data analysis tools adopted include descriptive and inferential statistics. Descriptive statistics such as frequency distribution mean and standard deviation will be used to analyse the data and provide answers to the research questions. Frequency distributions were computed to record responses from respondents on all items in the instrument. The variables computed were transformed into rating scales to derive summaries of descriptive statistics. Correlation and linear regression analysiswas used to give statistical responses to the research questions and hypotheses. All the hypotheses were tested at 5 percent level of significance ($\alpha = 0.05$). Data derived from completed instrument were computed and analysed using Statistical Package for Social Science (SPSS) version 21.0

Ethical Considerations Ethical approval was sought from Babcock University Health Research and Ethics Committee (BUHREC). An informed consent letter was administered seeking permission to conduct this study.

III. Results

Table 1: Respondents perceived benefits of health insurance scheme

S/N	Perceived Benefits	SA	A	U	D	SD
1	Kogi state health insurance scheme is likely to offer cheaper services	33(9.9)	113(33.7)	81(24.2)	47(14.0)	61(18.2)
2	Kogi state health insurance scheme may not relieve me of out-of-pocket payment	49(14.6)	93(27.8)	91(27.2)	85(25.4)	17(5.1)
3	Kogi state health insurance scheme will protect me and my family from high cost.	47(14.0)	121(36.1)	51(15.2)	68(20.3)	48(14.3)
4	If I am registered under the health insurance scheme; I can access emergency services without paying immediately	46(13.7)	124(37.0)	60(17.9)	48(14.3)	57(17.0)
5	The health insurance scheme does not provide preventive care and immunization	36(10.7)	62(18.5)	113(33.7)	84(25.1)	40(11.9)

Only 33.7% (113) of the respondents believed that the Kogi State health insurance scheme could offer cheap services while 9.9% (33) strongly agreed. Ninety three (27.8%) respondents agreed that the insurance scheme may not relieve them of the out-of-pocket payment methods and half perceived that the scheme will protect them and their families (Table 4.10). The proportions of respondents who strongly agreed and agreed that registering with the scheme can give them access to emergency services without payment were 37.0% (124) and 13.7% (46) respectively. Some of the respondents believed that the scheme does not provide preventive care and immunization. The level of perceived benefits was computed on a 15-point rating scale with a mean ±SD of 5.7343 ± 3.161. About a third (32.2%; 108) of the respondents had a high perception of benefits involved in enrolling in the scheme.

Table 2: Perceived barriers to health insurance scheme uptake

S/N	Perceived Barriers	SA	A	U	D	SD
1	Kogi state health insurance scheme is a deception from Government	39(11.6)	64(19.1)	94(28.1)	84(25.1)	54(16.1)
2	I may not participate in the health insurance scheme because most times they lack expensive drugs	70(20.9)	116(34.6)	52(15.5)	84(25.1)	13(3.9)
3	The amount I earn on monthly basis is little so, I am not interested in the health insurance scheme	41(12.2)	106(31.6)	41(12.2)	104(31.0)	43(12.8)
4	I may not participate in the health insurance scheme because of poor attitude of some health workers in the past	73(21.8)	84(25.1)	50(14.9)	96(28.7)	32(9.6)
5	I may not register under the health insurance scheme because is restricted to certain class of people (such as Directors, Commissioners, senior civil servants)	69(20.6)	36(10.7)	51(15.2)	110(32.8)	69(20.6)

About a third of the sample population (116; 34.6%) confirmed that they may not enrol in the scheme because they lack expensive drugs. Fifty four (16.1%) respondents disagree that the scheme is a deception from the government while 11.6% (39) of the population strongly agreed (Table 4.12). The monthly income of the respondents was another barrier reported to nonparticipation in the scheme. Almost half of the respondents agreed (25.1%) and strongly agreed (21.8%) that the poor attitude of the healthcare workers is a barrier to their uptake of the scheme. The misconception about the class of people who could register was another known barrier. Some of the respondents (20.6%) strongly agreed that the scheme is for only higher level officers. The level of barriers was computed on a 15-point rating scale and the mean ±SD was 6.56 ±2.948. Over half of the respondents (59.1%) had a low level of barriers to the uptake of health insurance scheme .

IV. Discussion

The barriers to uptake of the services identified by the respondents in this study included the poor attitude of healthcare workers, insufficient monthly earning and inadequate knowledge. The enrolees are to pay 10% of their monthly salary as contributions to the scheme. Unwillingness to enrol can be strongly related to the lack of knowledge of the services and poverty among the people. The reported barriers and misconceptions could be debunked if the individuals have adequate knowledge of the benefits in health insurance enrollment. Some of the respondents believed that the scheme is a form of deception by the government. This defines the lack of trust and uncertainty citizens have about the health care system.

The reported limiting factors also include individuals' perception about misappropriation of funds, politicking of the scheme and poor governance in the country. The scheme has been in existence in a corrupt, unaccountable system (Health Insurance Report, 2005). The country's social health insurance scheme since inauguration only covers 5% of the working population (Uzochukwu, Ughasoro Etiaba, Okwuosa, Envuladu & Onwujekwe, 2015). A study conducted by Oriakhi & Onemolease (2012) revealed that community members in

Edo State lacked trust on administrators and reported that government policies/programs were unstable and unsustainable.

V. Conclusion

The barriers to uptake will be eliminated when the people have adequate knowledge about the scheme. The goal of better health insurance coverage will be achieved if the informal sector embraces the scheme and awareness is promoted by marketers. Public education and media should be utilized to ensure faster dissemination to this sector.

VI. Recommendations

Based on the findings of this study, the following recommendations are hereby made

1. Awareness programs should target the artisans and informal sector to reduce misconceptions about the benefits, enrolment process and beneficiaries.

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